

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____ If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth? <input type="checkbox"/> Does it hurt to chew, bite or swallow? <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/> Do you clench or grind your teeth? <input type="checkbox"/> Does your jaw click, pop or hurt? <input type="checkbox"/> Do you have earaches or neck pains? <input type="checkbox"/> Does dental treatment make you nervous? <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			Yes No ?
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use vaping products ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Pregnant? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Nursing? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes No ?	Yes No ?
Aspirin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix). <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other
Codeine or other narcotics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience.
Iodine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
Latex (rubber)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Local anesthetics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Metals	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /	What is your normal blood pressure (systolic, diastolic)?
Doctor's Name: _____	Phone: _____

Please use an "X" to mark your answers to the following questions.

Are you in good physical health?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you currently being seen or treated by a physician?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answered yes to any of the above, please explain: _____	

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?		Yes No ?	Yes No ?
Heart (Cardiac) Health	Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Digestive Health
Pacemaker/implanted defibrillator	Type: _____		Gastrointestinal disease
Artificial (prosthetic) heart valve	Date of diagnosis: _____		G.E. reflux/persistent heartburn (GERD)
Previous infective endocarditis	Chemotherapy: _____		Stomach ulcers
Congenital heart disease (CHD)	Radiation treatment: _____		Eye (Vision) Health
Unrepaired, cyanotic CHD			Glaucoma
Repaired (completely) in last 6 months	Blood (Circulatory) Health		Other
Repaired CHD with residual defects	Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis
Arteriosclerosis	Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain
Coronary artery disease	If yes, date: _____		Diabetes (type I or II)
Congestive heart failure	Hemophilia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder
Damaged heart valves	High or low blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent infections
Heart attack	Brain (Neurological)/Mental Health		Type of infection: _____
Heart murmur/rhythm disorder	Anxiety	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease
Rheumatic heart disease	Depression	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Immune deficiency
Stroke	Epilepsy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems
Breathing (Respiratory) Health	Mental health disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition
Asthma (COPD)	Neurological disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis
Bronchitis	Post-traumatic stress disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis
Emphysema	Traumatic brain injury or concussion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted infection (STI)
Sinus trouble	Autoimmune Disease		Thyroid problems
Tuberculosis	AIDS or HIV Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
	Lupus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes No ?	Yes No ?	Yes No ?
had pain or tightness in the chest?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
been exposed to anyone with tuberculosis?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
had a rapid or irregular heart beat?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		experienced vomiting, diarrhea, chills, night sweats or bleeding?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		had migraines or severe headaches?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____



FINANCIAL POLICY & PAYMENT AGREEMENT

Thank you for choosing the professionals at Flanagan Dental to serve your dental needs. We are committed to providing excellent care. Please understand that payment for your dental care is part of your treatment. Please read and sign this statement.

PAYMENT IS DUE AT THE TIME OF SERVICE: We accept cash, checks, ACH, HSA, FSA, all major credit cards, and/or CareCredit® and Sunbit®. As a courtesy, we will submit any dental insurance claims on your behalf. Deductibles and copayments are **collected at the time of service**. Our fees reflect the standard price when paying by credit card. Patients who choose to pay by cash, check, ACH, debit card, HSA or an FSA card will receive a 3% courtesy discount at the time of payment. We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full prior to completion of care. Additionally, we have a partnership with CareCredit® and Sunbit®, which allows our patients with flexible financing options (see CareCredit® and SunBit® plan details). Any arrangements for third-party financing must be made **BEFORE starting treatment**.

REGARDING INSURANCE: We accept most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an **agreement between you and your insurance company**. You are ultimately responsible for all charges. **We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.** Please read and sign our Assignment of Insurance Benefits Agreement form on the following pages.

REASONABLE AND CUSTOMARY FEES: Our practice is committed to providing the best dental care for our patients and we charge fees which are usual and customary **for our area**. Patients are responsible for payment regardless of any insurance company's arbitrary determination based on their premium and coverage negotiations with employers.

TREATMENT PLANS: We require a **50% down payment BEFORE starting treatment plan**. A treatment plan may include, but is not limited to, crowns, bridges, and implants. For plans requiring more than two appointments, alternative payment arrangements may be provided. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. As mentioned above, we offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full prior to completion of care.

PAST DUE ACCOUNTS: Accounts without acceptable payment activity for 30 days will be considered past due. Accounts without acceptable payment activity for 30 days will incur a **fee of 18%** in addition to your current balance.

COLLECTIONS: Accounts without acceptable payment activity for 90 days will be sent to collections. If this becomes necessary, your account will be placed with an outside collection agency and you will not receive any further account notifications from our office.

MISSED APPOINTMENTS: If you have scheduled an appointment with the Doctor or Hygienist and need to cancel or reschedule, a **minimum of 24 hours' notice is required**. If you fail to provide adequate notice, **we reserve the right to cancel your appointment or bill you \$86 per hour** for the appointment you had reserved.



RETURNED CHECKS: A fee of \$50 will be billed to your account for returned checks.

MINORS: The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will not be performed, unless prior payment has been made or charges have been authorized by the parent or legal guardian to a valid credit card accepted by our office.

PHOTOGRAPHS: I give my permission to Flanagan Dental or any representative they may designate, to photograph me for diagnostic purpose and to enhance the medical record. I agree that these photographs will remain Flanagan Dental's property (this includes all diagnostic x-rays). I further authorize Flanagan Dental to use these photographs for teaching purposes, marketing (website, social media, print, advertising, etc.), to illustrate scientific papers, or for use in lectures. If any photographs are used for any reason I shall not be identified by name.

SIGNATURE RELEASE: I authorize the releases of dental/medical information necessary to either process my insurance claims for treatment performed by Flanagan Dental or when necessary, to other providers rendering medical/ dental care. I hereby assign to Flanagan Dental all dental, medical, and surgical benefits to which I am entitled for services rendered by Flanagan Dental. This assignment will remain in effect until revoked by me **in writing**. A copy of this assignment is to be considered as valid as the original.

Patient Name Printed _____

Patient Signature _____ Date _____

If patient is under 18:

I, [print name] _____, am the parent/legal guardian of
_____ [patient name]. By signing this form, I acknowledge that I
have completely read and fully understand this document and agree to be bound thereby.

Parent/Guardian Signature _____ Date _____



ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you and your insurance company. The following provisions identify our policies governing insurance claims.

By **signing below**, I am agreeing to the terms and conditions set forth in this agreement.

1. Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a **courtesy** we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important to understand that this does not eliminate your financial obligation for your treatment.
2. We require you to sign this form and any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payments directly to our office.
3. We require you to pay the co-insurance amount, (which is the amount not covered by your insurance company) at the time we provide service to you.
4. Insurance payments ordinarily are received within thirty (30) to sixty (60) days from the time of filing. If your insurance company has not made payment to our office within sixty (60) days, we will ask you to pay the balance due at that time. You will then be responsible for seeking reimbursement from your insurance company.
5. Our office does not guarantee that your insurance company will pay for treatment that you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying in full at that time.
6. Our office will not enter into a dispute with your insurance company over any claim. We will provide any necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and understand the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

Patient Name Printed _____

Patient Signature _____ Date _____

If patient is under 18:

I, (print name) _____, am the parent/legal guardian of _____ (patient name). By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Parent/Guardian Signature _____ Date _____



AUTHORIZATION TO RELEASE DENTAL RECORDS

I, _____, hereby request and give my permission to (name of doctor/office **sending** records) _____ to provide (name of doctor/office **receiving** records) _____ any and all information regarding past dental care for the following individual: _____ who's date of birth is: _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs (x-rays), models and copies of all dental records and medical records.

If sending to Flanagan Dental, please have these records sent to:

Flanagan Dental
56 Whitehall Avenue, Suite 3
Mystic, CT 06355
Phone: (860) 222-7500
Fax: (475) 356-3009
Email: frontdesk@flanagandental.com

Patient Name Printed _____

Patient Signature _____ Date _____

IF PATIENT IS UNDER 18:

I, (print name) _____, am the parent/legal guardian of _____ (patient name). By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Parent/Guardian Signature _____ Date _____



GENERAL CONSENT FOR ROUTINE DENTAL TREATMENT

Welcome to Flanagan Dental!

At Flanagan Dental, all of our dental healthcare providers constantly strive to communicate clearly and effectively with all of our patients, regarding all aspects of their dental care. There are however, many instances when sudden and unanticipated circumstances may arise, that may require the dentist or dental hygienist to provide immediate or emergency dental services.

As a patient, you have the right to accept or reject dental treatment recommended to you by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

We request that you only consent to treatment after first discussing the potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you acknowledge that you accept known risks and complications.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. Failure to follow the advice of your dentist may increase the chances of a poor outcome.

As a patient, you are an important part of the dental treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so that they can be addressed by your dentist.

Consent to Dental Treatment

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or a number of the following:

1. Administration of local anesthesia
2. Cleaning of the teeth and application of topical fluoride
3. Scaling and root planing (deep cleaning) with local anesthesia
4. Application of sealants to the grooves of the teeth
5. Treatment of diseased or injured teeth with dental restorations
6. The replacement of missing teeth with a dental prosthesis (crown, partials, implants, etc.)
7. Treatment of diseased or injured oral tissues (hard and/or soft)
8. Treatment of malposed (crooked) teeth and/or developmental abnormalities.
9. Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or root canal

Risk of Dental Procedures in General

Included [but not limited to] are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, bleeding, and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Reaction to injections or medications
5. Itching, bruising, delayed healing
6. Damage to adjacent teeth, restorations or gums
7. Possible deterioration of your oral health condition which may result in tooth loss
8. The need for replacement of restorations, implants or other appliances in the future
9. An altered bite in need of adjustment
10. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
11. Temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues
12. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
13. Need for follow-up treatment, including surgery
14. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Cardiac Conditions

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition, prosthesis, or murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

Birth Control

If you are a woman on oral birth control medication, we request that you consider that some antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are currently taking antibiotics.



Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during initial examination. Upon my consent, I will give permission to the dentist to make any/all changes and additions as discussed and deemed necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crowns (Caps), Bridges and Onlays

I understand that sometimes it is not possible to match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Name Printed _____

Patient Signature _____ Date _____

IF PATIENT IS UNDER 18:

I, (print name) _____, am the parent/legal guardian of _____ (patient name). By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Parent/Guardian Signature _____ Date _____



ADVANCE NOTICE TO PEOPLE WITH MEDICARE THAT

MEDICARE WILL NOT PAY FOR MOST DENTAL CARE & DENTURES

When you receive dental services that are not Medicare benefits, you are responsible to pay for them personally or through any other insurance that you may have. Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. When services (for example, most dental care services) are **not Medicare covered benefits**, Medicare will **not pay** for them.

The purpose of this advance notice is to help you make an informed choice about whether or not you want to receive these dental services, knowing that you will have to pay for them yourself. We do not send claims to Medicare for dental care or dentures that are always excluded from Medicare coverage.

Before you make a decision, you should read this entire notice carefully.

- **The Medicare program does not cover most routine dental services.** The Medicare law clearly excludes coverage “for services in connection with care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth” and dentists may not be required to submit Medicare claims for such services. *
- For people with Medicare, this means that Medicare will not pay for most routine dental care, such as fillings, cleanings, x-rays, and dentures, even if those services are performed in a hospital. **Payment for most dental care is your responsibility.**
- **A narrow exception permits coverage of certain dental services that are necessary to the provision of certain Medicare covered medical services.** For example, Medicare may cover the following services.
 - Extraction of a tooth as part of a repair of a fractured jaw.
 - Maxillofacial surgery for pathological or traumatic medical conditions (for example, in case of a serious injury).
 - Prosthetic rehabilitation to replace or treat certain oral and/or facial structures related to covered medical and surgical interventions (for example, cancer surgery).
 - Extraction of teeth prior to radiation treatment of the jaw.
 - Oral examination prior to kidney transplantation.
- **Medicare may also cover certain medical procedures that dentists are licensed to perform (for example, a biopsy for oral cancer).** *

*These are not all-inclusive lists. These examples are for illustrative purposes.

If you have any additional questions concerning Medicare coverage for dental services, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227).

This notice is published by: American Dental Association 211 East Chicago Avenue, Chicago, IL 60611. The Centers for Medicare & Medicaid Services has reviewed this ADA notice about dental coverage and confirmed the accuracy of its content. This notice is only a general summary of dental care exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.



CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN

PLEASE NOTE that if there are any medical changes, the parent or legal guardian **MUST** speak directly with the dental health care provider. If no changes, please check box next to child's name and initial.

Patient Name Printed _____

Patient's Date of Birth _____

This consent serves as permission for treatment by Flanagan Dental for the above-named child. The individual bringing my child to the appointment is _____. I give my authorization for all dental treatment including routine procedures that may be required during my absence: x-rays, exams, prophy, preventive procedures including sealants, as well as emergency dental treatment such as extractions, for the above-named child. I agree to pay for all services provided to my child.

This authorization shall remain effective (select one):

One (1) year from date signed below.

Until _____ (Month/Day/Year).

I, (print name) _____, am the parent/legal guardian of _____ (patient name). By signing this form, I give Flanagan Dental consent to treat the above listed patient. Treatment may include but is not limited to: Intra Oral x-ray, Panoramic x-ray, CBCT, Restorative Filling, Local Anesthetic, Nitrous Oxide, Crown, Pulpotomy, and Extraction.

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Flanagan Dental prior to the date signed below.

Parent/Guardian Name Printed _____ Phone # _____

Parent/Guardian Signature _____ Date _____



CONSENT TO COMMUNICATE ELECTRONICALLY

Patient Name: _____ Date of Birth: _____

(Initial below)

I _____ DO AGREE

I _____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

MY MOST PREFERRED METHOD OF ELECTRONIC COMMUNICATION:

(Initial below)

___ Text to Cell _____

___ Email Address _____

I WOULD LIKE TO RECEIVE:

___ Appointment Reminders/Recall Visits

___ Information regarding insurance/billing

___ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling: Flanagan Dental; (860) 222-7500 or by emailing us at frontdesk@flanagandental.com.

Patient Signature: _____ Date: _____

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. This material is for general reference purposes only and does not constitute legal advice. It covers only HIPAA, not other federal or state law. Changes in applicable laws or regulations may require revision. Dentists should contact qualified legal counsel for legal advice, including advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.



AUTHORIZATION TO RELEASE DENTAL RECORDS

I, _____, hereby request and give my permission to (name of doctor/office sending records) _____ to provide (name of doctor/office receiving records) _____ any and all information regarding past dental care for the following individual: _____ who's date of birth is: _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs (x-rays), models and copies of all dental records and medical records.

If sending to Flanagan Dental, please have these records sent to:

Flanagan Dental
56 Whitehall Avenue, Suite 3
Mystic, CT 06355
Phone: (860) 222-7500
Fax: (475) 356-3009
Email: frontdesk@flanagandental.com

Patient Name Printed _____

Patient Signature _____ Date _____

IF PATIENT IS UNDER 18:

I, (print name) _____, am the parent/legal guardian of _____ (patient name). By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Parent/Guardian Signature _____ Date _____



HIPAA AUTHORIZATION TO DISCLOSE BILLING & HEALTH INFORMATION

Patient Full Name: _____

Date of Birth: _____

Many patients choose to permit family members—such as a spouse, parent, or other designated individual—to communicate with Flanagan Dental regarding dental treatment, insurance matters, and/or billing information. Under the Health Insurance Portability and Accountability Act (HIPAA), we are prohibited from disclosing any protected health information without the patient’s written authorization.

If you wish to authorize Flanagan Dental, to disclose your dental treatment, medical, insurance, and/or billing information to specific individuals, you must complete and sign this authorization form. This authorization applies **only** to the individual(s) listed below and **only** to the information expressly permitted herein. No other information may be disclosed under this authorization.

This authorization remains in effect until revoked. You may revoke this authorization at any time by submitting a written revocation to our office. Revocation will not apply to information already disclosed in reliance on this authorization. I hereby authorize Flanagan Dental to disclose my dental treatment, medical, insurance, and/or billing information to the following individual(s):

Name: _____

Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

Phone Number: _____

Phone Number: _____

Patient Name Printed _____

Patient Signature _____ Date _____

If patient is under 18:

I, [print name] _____, am the parent/legal guardian of _____ [patient name]. By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Parent/Guardian Signature _____ Date _____



MYSTIC DENTISTRY, LLC

Doing business as Flanagan Dental

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is important to us.

OUR LEGAL DUTY

Mystic Dentistry, LLC, doing business as Flanagan Dental (“we,” “our,” or “us”), is required by federal and state law to maintain the privacy of your protected health information (“PHI”), to provide you with this Notice of Privacy Practices, and to follow the terms of this Notice while it is in effect.

This Notice describes how we may use and disclose your health information, your rights regarding your health information, and our legal duties.

Effective Date: February 1, 2026

We reserve the right to change our privacy practices and the terms of this Notice at any time, as permitted by law. Any changes will apply to all PHI we maintain, including information created or received before the changes were made. If we make a material change, we will update this Notice and make the revised Notice available at our office and upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION (WITHOUT AUTHORIZATION)

We may use or disclose your health information without your authorization for the following purposes:

Treatment

We may use or disclose your health information to provide, coordinate, or manage your dental care. For example, we may share information with other healthcare providers involved in your treatment.

Payment

We may use and disclose your health information to obtain payment for services we provide, including billing dental insurance plans and confirming coverage.

Healthcare Operations

We may use and disclose your health information for practice operations such as quality assessment, staff training, licensing, credentialing, auditing, and business planning.



Appointment Reminders & Care Communications

We may contact you to remind you of appointments or provide information about treatment or services. Communications may include phone calls, voicemail messages, text messages, emails, postcards, or letters. You may request alternative communication methods at any time.

Persons Involved in Your Care

We may disclose health information to a family member, personal representative, or other person involved in your care or payment for your care, as permitted by law and consistent with your preferences.

Disaster Relief

We may disclose health information to assist in disaster relief efforts.

Required by Law & Public Health Activities

We may disclose health information when required by law, including for public health reporting, health oversight activities, judicial or administrative proceedings, law enforcement purposes, workers' compensation, or to avert a serious threat to health or safety.

Business Associates

We may disclose health information to third-party vendors who perform services for our practice (such as billing, practice management software, IT support, and data storage). These vendors are required by law and contract to safeguard your information.

SPECIAL PROTECTIONS FOR CERTAIN HEALTH INFORMATION

[42 CFR PART 2]

Certain health information related to substance use disorder treatment may be protected by additional federal confidentiality rules [42 CFR Part 2].

- Such information may not be used or disclosed for civil, criminal, administrative, or legislative proceedings against you without your written authorization or as otherwise permitted by law.
- Re-disclosure of this information is generally prohibited unless expressly permitted by law.
- You have specific rights related to the use and disclosure of this information.

If applicable, these additional protections will be honored as required by law.

USES AND DISCLOSURES REQUIRING AUTHORIZATION



We will not use or disclose your health information for marketing purposes, sale of information, or other purposes not described in this Notice without your written authorization. You may revoke an authorization in writing at any time, except to the extent action has already been taken.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

Access & Copies

Request to inspect or obtain copies of your health information. Requests must be made in writing. We will provide records in the format you request if reasonably practicable.

Fees: Any fees charged will be reasonable and cost-based, as permitted by law. No per-page fees will be charged for electronic records.

Amendments

Request an amendment to your health information if you believe it is incorrect or incomplete.

Accounting of Disclosures

Request a list of certain disclosures made within the last six years, excluding disclosures for treatment, payment, and healthcare operations.

Restrictions

Request restrictions on certain uses or disclosures. We must agree to requests to restrict disclosures to a health plan for services paid out-of-pocket in full.

Alternative Communications

Request confidential communications by alternative means or locations.

Paper Copy

Receive a paper copy of this Notice at any time, even if you agreed to receive it electronically.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice or believe your privacy rights have been violated, you may contact us or file a complaint.

You may also file a complaint with the U.S. Department of Health and Human Services. Filing a complaint will not result in retaliation.



CONTACT INFORMATION

Privacy Contact:

Dennis Flanagan, DDS, MSc

Practice:

Mystic Dentistry, LLC

Doing Business As: Flanagan Dental

Telephone: [860] 222-7500

Email: frontdesk@flanagandental.com

Address:

56 Whitehall Avenue, Suite 3

Mystic, CT 06355

ACKNOWLEDGMENT OF RECEIPT

Notice of Privacy Practices

I acknowledge that I received a copy of **Mystic Dentistry, LLC's (DBA Flanagan Dental)** Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

If patient is under 18:

I am the parent or legal guardian of the patient named above.

Parent/Guardian Name: _____

Signature: _____

Date: _____

For Office Use Only:

Acknowledgment not obtained because:

Patient refused

Communication barrier

Emergency situation

Other: _____



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I, _____, hereby request and give my permission to (name of doctor/office sending records) _____ to provide (name of doctor/office receiving records) _____ any and all information regarding past dental care for the following individual: _____ who's date of birth is: _____.

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